AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 04/12/2012			ETED		
NAME OF PROVIDE		ND SKILLED NURSING CENTE		STREET A	ADDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129		
TAG REG	EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Comp Federallega Surve Facili Provi AIM Surve Doro Avon Donn Censi SNF: SNF/ Total Censi Medi Medi Priva Other Total	plaint IN00 pplaint #IN00 pral/State def gations are ci ey dates: Ap lity number: ider number number: 10 ey team: othy Navetta na Connell, I na Groan, RI sus bed type: : 8 /NF: 62 l: 70 sus payor type icare: 17 icaid: 38	0105884 Substantiated . Siciencies related to the ted at F282, F323 oril 10, 11, 12, 2012 000059 : 155697 0266560 , RN TC RN N	FOO	000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000059

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CO A. BUILDING B. WING	00 	COMPI 04/12	LETED
CLARK R		ND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
TAG	These deficiencie	es also reflect State accordance with 410 IAC pleted 4/16/12	TAG	DEFICIENCY		DATE

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Event ID: 3WGI11

Facility ID: 000059

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155697	B. WING			04/12/	2012
			B. WIN		ADDRESS OVEN STATE OF CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ITTLE LEAGUE BLVD		
CLARK REHABILITATION AND SKILLED NURSING CENTER				CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DE CAMPANIA DE LA CAMPANIA DE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ĪΕ	DATE
F0282	483.20(k)(3)(ii)	, in the second					
SS=D	(/(/(/	QUALIFIED PERSONS/PER					
00-B	CARE PLAN	governes renderion en					
		vided or arranged by the					
		provided by qualified persons					
		ith each resident's written					
	plan of care.						
	Based on observa	ation, record review and	F02	82	What corrective action(s) will b	е	04/20/2012
		ility failed to ensure the			accomplished for those reside		:s
		in place for a resident at			found to have been affected by		
		nis deficient practice had			the deficient practice? -Resident		
		-			D's chair alarm was placed an		
	•	ffect 1 of 4 residents	How other r		checked for proper functioning. How other residents having the		
	reviewed for falls	s in a sample of 10.			_		
	(Resident D)				potential to be affected by the same deficient practice will be		
					identified and what corrective		
	Findings include				action(s) will be taken? - All	5	
	i mamgs merade	•			residents have the potential to	he	
	m 1: : 1	10 8 11 15			affected by the alleged deficien		
		rd for Resident D was			practiceNursing staff will be		
	reviewed on 4/11	1/12 at 9 a.m. The			re-educated by 4/20/12 by the		
	resident's diagno	ses included, but were			DNS/designee on the fall		
	not limited to Par	rkinson disease, fractured			management program, review	of	
	femur and demer	-			aide assignment sheet Q shift	for	
	Terriar and derrier	itiu.			special needs and		
	D1 '' T1 1				placement/functioning of assis		
		none Orders dated			devices, and communication fr	rom	
	3/12/12 included	, but were not limited to:			charge nurse to caregiver of		
	"3. Chair alarm	@ (at) all times when up			specific care required for		
	in G/C (gerichair	c) 6. G/C when up			assigned residentsAn assistiv	/e	
	R/T WBAT (We	-			device log has been implementedAll residents with	h	
	*				falls and assistive devices hav		
	, ,	ight) leg 2nd degree hip			been reviewed to ensure each		
		rease in cognition with			resident is receiving adequate		
		own safety limitations			supervision to prevent acciden	ts	
	2nd degree to der	mentia."			and follow-up through CQI mir		
	-				tools will be utilized, as needed		
	The following of	oservations were made on			to ensure practice is being		
	•	5501 vations were made on			followedAlarms and assistive		
	4/11/12.				devices will be checked daily p	er	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUM		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
155697		155697	A. BUII B. WIN			04/12/2	2012
			D. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER						
		NID CIVILLED NUIDCING CENTED			ITTLE LEAGUE BLVD		
CLARK REHABILITATION AND SKILLED NURSING CENTER				CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					shift for placement and		
	10:17 AM Dogid	ent D was seated in a			functioning by the charge nurs	se	
					by signing off on the TAR.		
	_	Nurse's Station. A			-Non-compliance with these		
	personal alarm w	as lacking on the geri			practices will result in further		
	chair.				education including disciplinar	y	
					actionDirector of Nursing		
	11.50 AM Dagid	ent D was seated in a geri			Services/designee is responsi	ble	
		2			to ensure compliance. What		
		. A personal alarm was			measures will be put into pla	ice	
	lacking on the ge	eri chair. In interview			or what systematic changes		
	with CNA #1, sh	e checked Resident D			will be made to ensure that t	he	
	and indicated a n	ersonal chair alarm was			deficient practice does not		
	•	nair. Review of the CNA			recurNursing staff will be		
					re-educated by 4/20/12 by the		
	_	t for Special Needs, at			DNS/designee on the fall	_	
	this time, indicat	ed Resident D was to			management program, review		
	have a "chair ala	rm on at all times"			aide assignment sheet Q shift	for	
					special needs and		
	In interview with	LPN #2, at this time,			placement/functioning of assis		
					devices, and communication for	rom	
		hair alarm should have			charge nurse to caregiver of specific care required for		
	been placed on the	ne residents chair.			assigned residentsAn assisti	VA	
					device log has been	vo	
	On 4/11/12 at 2:5	55 PM, the Administrator			implementedAll residents wit	_h	
		rided the Policy and			falls and assistive devices hav		
	U	e Fall Management			been reviewed to ensure each		
					resident is receiving adequate		
	_	3/10 which included, but			supervision to prevent accider		
	was not limited t	o: "Procedure: Fall Risk			and follow-up through CQI mir	nute	
	4. Charge nurses	s will communicate the			tools will be utilized as needed	d to	
	specific care requ	uired for each resident to			ensure practice is being follow		
		egiver on each shift."			-Alarms and assistive devices	will	
	and assigned care	giver on each sinit.			be checked daily per shift for		
					placement and functioning by		
	_	relates to Complaint			charge nurse by signing off on		
	IN00105884.				TARNon-compliance with the	ese	
					practices will result in further		
	3.1-35(g)(2)				education including disciplinar	У	
	J.1-JJ(8)(2)				actionDirector of Nursing		
			1		Services/designee is responsi	pie	

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	OF CORRECTION	IDENTIFICATION NUMBER: 155697	A. BUILDING B. WING	00	COMPLETED 04/12/2012
	PROVIDER OR SUPPLIEF	NO SKILLED NURSING CENTE	517 N I	ADDRESS, CITY, STATE, ZIP CODI LITTLE LEAGUE BLVD (SVILLE, IN 47129	ь
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	DBE COMPLETION
				to ensure compliance. He corrective action(s) will I monitored to ensure the deficient practice will no I.e., what quality assurar program will be put into place?-The CQI audit too falls will be utilized weekly monthly x2, and quarterly thereafterThe CQI commovill review audits and activill be developed, as need improve compliance. Noncompliance with facility and procedure may result employee education and/disciplinary action up to an including termination.	t recur, nce I for / x4, mittee on plans ded, to ty policy in or

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					` ′	DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPL	
	155697		B. WING 04/12			04/12/	2012
NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER			<u>-</u>	517 N L	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD (SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
F0323 SS=G	The facility must environment rem hazards as is poreceives adequa assistance device. Based on record facility failed to had a history of a without assistance to prevent an accresident sustaining deficient practice effect 1 of 5 resident a sample of 10. Findings include The clinical recordinate recordinate deficient practice of the clinical recordinate resident's diagnoral not limited to Paragress Notes in limited to: 03/02/12 5:07 PN chair) in dining removed chair allocations and the chair alarms fund	ensure that the resident pains as free of accident ssible; and each resident te supervision and es to prevent accidents. The review and interview the ensure a resident, who attempting transfers te, received supervision eident resulting int he ag a fractured hip. This is had the potential to dents reviewed for falls to (Resident D)	F03	23	What corrective action(s) will be accomplished for those resider found to have been affected by the deficient practice? -Reside D's chair alarm was placed and checked for proper functioning. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? - All residents have the potential to affected by the alleged deficien practiceNursing staff will be re-educated by 4/20/12 by the DNS/designee on the fall management program, review aide assignment sheet Q shift special needs and placement/functioning of assist devices, and communication fro charge nurse to caregiver of specific care required for assigned residentsAn assistive device log has been implementedAll residents with falls and assistive devices hav been reviewed to ensure each resident is receiving adequate supervision to prevent accident and follow-up through CQI mintools will be utilized, as needed to ensure practice is being followedAlarms and assistive	nts y nt d heee ee be nt of for tive rom we h ee tts nute d,	04/20/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 155697 04/12/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 517 N LITTLE LEAGUE BLVD CLARK REHABILITATION AND SKILLED NURSING CENTER CLARKSVILLE. IN 47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG devices will be checked daily per noncompliant with transfers/alarms this shift for placement and shift x 3 attempting to take self to functioning by the charge nurse bathroom and to get in his closet, pt by signing off on the TAR. educated on safety and use of the call -Non-compliance with these light, pt up in wheelchair at this time" practices will result in further education including disciplinary action.-Director of Nursing 03/06/12 1:39 AM "Around 1249 resident Services/designee is responsible was standing up in wheel chair attempting to ensure compliance. What to adjust himself better in the chair and measures will be put into place or what systematic changes lost his balance landing on his right hip, will be made to ensure that the CNA was entering residents room at the deficient practice does not time of the incident and was a witness to recur. -Nursing staff will be the fall. apron (sic) assessment res c/o re-educated by 4/20/12 by the (complains of) some pain to right hip, DNS/designee on the fall management program, review of [named nurse practitioner] notified n/o aide assignment sheet Q shift for (nursing order) to send to er for special needs and evaluation, residents V/S (vital signs) placement/functioning of assistive stable, resident instructed to remain in devices, and communication from charge nurse to caregiver of floor until ambulance arrive, CNA specific care required for remained with resident for safety..." assigned residents.-An assistive device log has been 03/06/12 6:19 AM "Called hospital for implemented.-All residents with falls and assistive devices have update of resident, resident was admitted been reviewed to ensure each with right hip fracture..." resident is receiving adequate supervision to prevent accidents Signed Physician's Orders for March 3012 and follow-up through CQI minute tools will be utilized as needed to included, but were not limited to "Up in ensure practice is being followed. wheelchair daily w (with) alarming self --Alarms and assistive devices will release seat belt to alert staff resident is be checked daily per shift for attempting to rise by self R/T (related to) placement and functioning by the charge nurse by signing off on the ataxia/Parkinson, dementia..." TAR.-Non-compliance with these practices will result in further The Care Plan with last care conference education including disciplinary of 03/30/2012 included but was not action.-Director of Nursing

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PRINTED: 05/01/2012 FORM APPROVED OMB NO. 0938-0391

			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	155607		A. BUII	LDING	00	COMPLE 04/12/2	
		155697	B. WIN			04/12/2	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CLARKE	REHARII ITATION A	ND SKILLED NURSING CENTER			ITTLE LEAGUE BLVD SVILLE, IN 47129		
					O VILLE, IIV 47 120	1	(V.5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	limited to: "Prob	olem Start Date:			Services/designee is responsib	ole	
		dent at risk for falls R/T			to ensure compliance. How the	ie	
	hx (history) of fa				corrective action(s) will be		
		e) med use, dx (diagnosis)			monitored to ensure the deficient practice will not rec		
		emors, DM (diabetes			I.e., what quality assurance	ui,	
	· ·	tia, R (right) hip fx,			program will be put into		
	· ·	functional mobility			place?-The CQI audit tool for		
	tasks, poor safety	-			falls will be utilized weekly x4,		
	' '	c) with seeking assist			monthly x2, and quarterly thereafterThe CQI committee	e	
	with transfers, di	sarms alarms, non			will review audits and action pl		
	compliant with u	se of devices, i.e. (for			will be developed, as needed,	to	
	example) reacher	r, self release seat belt,			improve compliance. Noncompliance with facility po	liov	
	call light use, etc	. Goal Target Date:			and procedure may result in	licy	
	06/30/2012 Will	decrease resident's risk			employee education and/or		
	of falls. Approac	ch Start Date 01/05/2011			disciplinary action up to and		
	Check placemen	t and functioning of			including termination.		
	alarm q shift and	prn. Approach Start					
	Date: 01/05/201	1 Keep call light in					
	reach at all times	s. Approach Start Date:					
	01/05/2011 Prov	ide toileting assistance					
	per schedule toil	eting					
	Review of the M	onthly Summary form					
	for Scheduled To	oileting indicated					
	"Program #2 Toi	let upon rising, before or					
	after meals, at be	edtime and check and					
	change through t	he night"					
		30 PM, in interview with					
		etor of Nursing, when					
	. •	ether or not the resident					
		at the time of the fall she					
	made no comme	nt.					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURV COMPLETED 04/12/2012	1
	PROVIDER OR SUPPLIER	.ND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COM	(X5) MPLETION DATE
	in training provided Program revised was not limited to of American Sent ensure residents a facility will main functioning through physical, environg guidelines to prefalls. Procedure: nurses will common required for each caregiver on each Con 4/11/12 at 10 with LPN #1, she don't remember, The resident tend could reposition	:33 PM, in interview e indicated "honestly I if he had the seatbelt on. ded to take it off so he				

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